REMARKS

This Office Action Response is responsive to a first non-final Office Action dated August 10, 2005, filed in response to a request for continuing examination filed on February 28, 2005. Claims 1-20 are pending, and claims 1-20 currently stand rejected.

Claims 1-20 are Nonobvious.

The Examiner has rejected Claims 1-20 under 35 U.S.C. § 103(a) as being unpatentable over Javors (US 2002/0152097), Glass *et al.* (Incentive-Based Physician Compensation Models, July 1999), and Khorasani, *et al.* (US 6,029,138) in view of Dang (US 6,370,511). Applicants respectfully disagree.

Javors, Glass *et al.*, Khorasani, *et al.* and Dang Each Fail To Recognize The Problems Addressed By Applicants' Claimed Invention.

As an initial matter, neither Javors, Glass et al., Khorasani et al. nor Dang recognize the problems, toward which Applicants' claimed invention is directed to solving. The Supreme Court has long acknowledged that recognition of a problem not previously recognized by others is part of the invention and, Applicants submit, is an indicator of nonobviousness of an invention. *See Eibel Process Co. v. Minnesota & Ontario Paper Co.*, 261 U.S. 45 (1923). Accordingly, as set forth extensively in the "Background" section of the instant application, Applicants have recognized that previous methods of managing healthcare practice groups have numerous disadvantages and have been largely unsuccessful in the climate and times of the instant application. For example, as set forth in the "Background" section of the present application, Applicants recognized that, in healthcare practice group management, such as a plurality of physicians in a practice group, managing the practice group effectively with respect to ancillary medical costs can be the difference between losing money and not. Applicants also recognized that the existing healthcare system will be difficult or impossible to overhaul, and Applicants have recognized a novel and nonobvious method of consulting with healthcare practice groups to thereby reduce the risk that these groups lose money. As a result, those within the group, such as physicians, can more effectively manage their healthcare practice. Applicants, however, have now provided an elegant solution to these problems. Such problem recognition and elegant solution are not found in the cited art, alone or in combination.

In contrast, the purpose of Javors, for example, is to provide a whole new healthcare management model. It specifically talks about the problems with the current healthcare model. Although overhauling the current healthcare model may have some merits, such overhauling is not the purpose of the present claimed invention, and such overhauling entails significant political, financial, economical, and other types of disadvantages. Also, unlike the present claimed invention, Javors clearly fails to recognize the problems with current management of healthcare practice as recognized by Applicant, fails to recognize how to provide incentives to those within the practice group as claimed, and clearly fails to recognize such an elegant solutions to enhance managing such healthcare practice groups as set forth in the instant application.

Glass et al. describes a physician productivity-influencing model to increase the number of patients seen by a physician. Accordingly, Glass simply is not directed to collecting fees for enhancing management of a plurality of physicians or an insurance network. For example, Glass first describes compensation methods utilized at progressive phases of capitation, namely Introductory, Transitional, and Substantial. Each of these phases emphasizes productivity, e.g., Introductory--"[t]he more procedures performed and patients seen, the more physicians are paid," (see paragraph 3), Transitional--"[r]ewards are structured mainly around productivity" (see paragraph 11), Substantial--"[a]s physicians become more efficient, they must be motivated to care for larger populations in order to keep their productivity at appropriate levels" (see paragraph 14). Again, with all respect, Applicants claimed invention is <u>not</u> directed to productivity of the physicians in a practice group.

Also, the Examiner previously suggested that although ancillary medical costs per se were not disclosed in Glass, the terms "ancillary services" (paragraph 6) and "ancillary utilization" (paragraph 30) were used. Applicants agree and appreciate the Examiners pointing this out to Applicants, but Applicants respectfully submit that Glass still fails to suggest collective fees and still fails to recognize the problem associated with ancillary medical costs as identified by Applicants. For example, the first use of "ancillary services" in paragraph 6 of Glass is in the context of describing a Transitional phase of a practice where the practice begins to supplement the fee-for-service revenues in the Introductory phase with prepaid revenues. In such a Transitional phase (recognizing that rewards are still structured mainly around productivity in this phase), among a plurality of new objectives, including larger patient panels,

increased patient satisfaction, a greater focus on preventative care, and fewer out-of-group referrals, Glass dismissively suggests that the practice would have an objective of "decreased use of ancillary services[,]" but says no more. From the preceding sentence(s) and the following sentence(s)/paragraph(s) surrounding this quote, we can glean that this is because the groups are inefficient, and this lack of efficiency causes activities that were once profitable to be loss leaders. Hence, it seems to suggest that use of ancillary services is inefficient, and it is unclear as to whether it is the cost of these services within a practice group, referrals to other companies that perform ancillary services, or the time involved causes the physician to be less productive. This description then provides two suggested incentive plans for the practice during this phase, namely (1) align a compensation formula for the physicians with the reimbursement system to reward "productivity for fee-for-service plan patients" and "efficiency for capitated plan patients" (now thereby shedding light on the new objectives being directed to efficiency under capitation plans--which Applicants submit is really how many patients do you see, not refer patients out to other groups, and not using ancillary services, which are all productivity measurements); and (2) salary plus production incentive where "rewards are structured mainly around productivity," and "benchmarking productivity is critical for maintaining group standards while transitioning to higher levels of capitation." Hence, it is clear that this obfuscated reference to "decreased use of ancillary services" as one among many objectives is directed to increasing efficiency and productivity and not to reduce ancillary medical costs per se, and especially not to a recognition of reducing ancillary medical costs, collecting fees or distributing savings from these reduced costs among the physicians.

The second use of "ancillary utilization" in paragraph 30 of Glass is in context of describing the Substantial phase. In the Substantial phase (over 50% capitation), Glass suggests that "productivity benchmarks are often overlooked at this stage." As physicians become more efficient, productivity needs to be maintained (again indicating productivity is an emphasis in the Transitional phase, as well as the Glass article as a whole) by production incentives. In this phase, Glass suggests that physicians can be paid a straight salary (but it is hard to maintain productivity) (see paragraph 15) or a salary plus incentive component can be implemented (see paragraph 17).

The Glass article then launches into a description of challenges in this Substantial phase and followed by a description of productivity and performance measures. Performance-based

incentives include patient satisfaction, utilization and cost of service, quality of care, administrative duties and collegiality, teamwork, peer reviews, and academic teaching and research (see paragraph 28). Within the utilization and cost service, there are wide varieties of measurement, such as expenditures per RVU, cost per encounter, PMPM utilization, use of physician extenders, average length of stay, as well as the second instance of use by Glass of "ancillary utilization" (see paragraph 30), but again says no more. This second instance, likewise, is totally unrelated to the present claimed invention and still makes the patient seem like only a unit on a production assembly line. Glass fails to teach or suggest the elegant and effective solution proposed by Applicants for beneficial and more effective healthcare practice group management so that physicians, insurance companies, and patients all benefit.

Then, Glass transitions into describing their proposed "RVU Physician Compensation Model" using relative value units (RVUs) where "clinical productivity is measured in RVUs" (paragraph 41) and never references or uses the "ancillary services" or "ancillary utilization" again. The RVU model also uses Medicare's Resource-Based Relative Value Scale (RBRVS) because work and practice expense components are split by procedure (paragraph 41). So, RVUs are explained in terms of RVU-work and RVU-PE (see paragraphs 44-46). Accordingly, if RVU is a measurement of "productivity," then RVU-work and RVU-PE clearly are likewise measurements of productivity.

For example, Glass even states that RVU-PE "is derived from the baseline projected clinical productivity" (paragraph 45). As for RVU-work, Glass states that this is a combination of clinical activity (again based on productivity) and non-clinical activity. Glass suggests that because non-clinical activity is not normally measured in terms of RVUs, RVU-work proxies (also tied to productivity) are developed to establish baseline or budgeted RVU-work. So, RVU-work is a combination of the RVU based on clinical activity and RVU proxies budgeted as measurements for non-clinical activity--again both still associated with productivity. Then, it should be apparent that reference in paragraph 47 of Glass to a compensation model in terms of Actual RVU-work, Budgeted RVU-work, Actual PE, Budgeted PE, Actual RVU-PE, and Budgeted RVU-PE are all associated with physician productivity.

Therefore, when performance is determined, measured, or budgeted in terms of RVUs, it should be clear that this performance is associated with productivity of the physician. As such, Applicants still submit that Glass fails to recognize the problem identified by Applicants related

ancillary costs, collecting fees, creating incentive pools, and modifying physician behavior to address the ancillary medical costs.

Khorasani et al. further fails to recognize the problems addressed by Applicants and fails to provide any solutions for such problems (which, of course, it fails to recognize). Khorasani et al. is directed to solving problems related to diagnosing patient symptoms, namely with diagnostic and therapeutic tests for a physician to select to use on a patient based on results of similar tests used on other patients. In other words, the problems recognized by Khorasani et al. relate to the selection of inappropriate or ineffective tests on patients "by sparing patients from unnecessary procedures which may delay time to reach a correct diagnosis or may subject the patient to unnecessary risks." (Col. 1, lines 22-24).

Dang further fails to recognize the problems addressed by Applicants and fails to provide any solutions for such problems (which, of course, it fails to recognize). Dang describes a patient classification system that accounts for differences in patient severity and establishes defined units of analysis. (Col 2, lines 5-8). The system includes a computer-implemented method for profiling medical claims which groups health care services into episode treatment groups. (Col. 6, lines 21-28). Unlike the claimed invention, Dang focuses on administration instead of cost control, quantifying casemix-adjusted differences in direct patient management and comparing them to others. (Col. 10, line 61 to col. 11, line 18). In fact, Dang effectively teaches away from any systems or methods that would seek to eliminate unnecessary services, including those described in the present application. (See Col. 1, lines 56-59 (stating that "[s]ystems that detect inappropriate coding, eliminate potentially inappropriate services[,] or conduct encounter-based payment methodology are insufficient for correcting the inconsistencies of the healthcare system.")). Dang further fails to offer a change process or solution. Dang also does not show which cooperative entity should be responsible for the costs. In contrast, the claimed invention offers a solution for measuring or controlling costs and cost-effectiveness of care, showing how to cause or affect the change.

As such, Applicants respectfully submit that to somehow use these completely different patent documents each of which fails to recognize the problems which Applicants both recognize and address and which each have completely different purposes from each other and from the present claimed invention, is awkward, is improper, and would not be what one skilled in the art would look to do in order to somehow arrive at the present claimed invention. Stated another

way, the four cited patent documents have nothing to do with each other, the problems addressed and purposes of Javors, Glass et al., Khorasani et al., and Dang are completely different, the systems and methods of these patent documents are completely different, and the software/hardware technology concepts used to accomplish the purposes therein are completely different. Thus, Applicants respectfully submit that to somehow attempt to combine selected portions of these patent documents that fail to recognize the problems addressed by Applicants claimed invention or to have related purposes, to then somehow arrive at the claimed invention, is improper. For this reason alone, Claims 1-20 define over the cited art.

No Proper Prima Facie Case of Obviousness Has Been Set Forth As Required.

To establish a proper prima facie case of obviousness, three basic criteria must be met. First, there must be some suggestion or motivation, either in the references themselves or in the knowledge generally available to one of ordinary skill in the art, to modify the reference or to combine reference teachings. Second, there must be a reasonable expectation of success. Third, the prior art reference (or references when combined) must teach or suggest all the claim limitations. The teaching or suggestion to make the claimed combination and the reasonable expectation of success must both be found in the prior art and not based on the Applicants' disclosure. *In re Vaeck*, 947 F.2d 488, 20 USPQ2d 1438 (Fed. Cir. 1991); *see also* MPEP 706.02(J). The Applicants respectfully submit that the Examiner fails to both factually support each element of the *prima facie* case of obviousness and fails to set forth a proper *prima facie* case.

No Suggestion or Motivation to Modify or Combine Reference Teachings.

First, there is no suggestion or motivation in any of the cited patent documents themselves or in the knowledge generally available to one of ordinary skill in the art, to modify the reference or to combine reference teachings. The Examiner has the burden of proffering a showing of this motivation to combine, and no real support or evidence has been set forth by the Examiner other than improper speculation, conjecture, and piecemeal hindsight.

Instead, it appears the Examiner has improperly and inadvertently read Applicants' disclosure to find the motivation and incentive within Applicants' disclosure and then attempted to combine piecemeal sections of Glass into Javors by saying that such a combination is justified by "the motivation of aligning incentives with the goals of the a healthcare practice and

encouraging others to adopt new behaviors consistent with the group's strategic goals (See Paragraph 46 of Glass)". The Applicants respectfully submit, however, that the Examiner has disregarded the basis for the incentives suggested in Glass (or what Glass teaches as a whole), namely "the more procedures performed and patients seen, the more physicians are paid" and "[a] selected percentage of the dollar value of production by each provider is the compensation component" (See Paragraph 3 of Glass). The RVU compensation model is based on productivity (throughput based on the number of patients seen by a physician---again the assembly line approach) and performance (budgeted level versus actual level of patient satisfaction, number of patients seen, etc.). So, in the "proper" context, what Paragraph 46 of Glass is actually saying is that "[i]t is important to have physician leaders embrace the plan" (namely the RVU Compensation Plan) in order to align incentives in the RVU Compensation Plan with productivity and performance "goals of the practice" to encourage others to adopt new behavior (namely productivity and performance behaviors) and to "buy into the new program" (RVU Compensation Plan). The teaching in Glass is to align productivity and performance goals of the RVU Compensation Plan for physician leaders and is not focused on problems associated with "ancillary medical costs" in a healthcare practice group. With all do respect, and with this "proper" context in mind, the Examiner either has misunderstood or misapplied this Glass teaching in an attempt to establish some kind of "out of context" hindsight motivation. Clearly, Glass provides no motivation to combine with Javors, and, for the Examiner to set forth that "paying funds from the funded incentive pool to the healthcare practice participating in the insurance network when the ancillary medical costs of the plurality of physicians in the healthcare practice do not decrease to a preselected level over a preselected period of time" is well known in the art is simply wrong. As such, Applicants suggest that the Examiner's evidence of motivation is improper and non-existent.

Also, the existence of a lack of evidence of a suggestion or motivation to combine is amplified by the prior admission that the combined teachings of Javors and Glass do not disclose "establishing a relationship between a healthcare consultation group and the healthcare practice participating in the insurance network to increase the plurality of physicians' profitability by reducing a risk of the healthcare practice not receiving a predetermined reimbursement amount for ancillary medical costs from the insurance network; modifying behavior of at least one of the plurality of physicians in the healthcare practice for management of the ancillary medical costs;

and distributing predetermined percentages of savings attributed to the modifying behavior of the plurality of physicians' ancillary medical cost management." (Paper No. 09172004, pages 3-4). In other words, in addition to the improper context used by the Examiner as alleged evidence, significant elements of the claimed invention remain missing with the combined teachings. Applicants respectfully submit that such missing elements further highlight why someone skilled in the art, in fact, would have no motivation to combine Javors and Glass, especially absent Applicants teachings in the instant application. How would one skilled in the art even consider, let alone go about, finding such a motivation without the improper use of hindsight? Again, no "proper" evidence of some suggestion or motivation to combine Javors and Glass has been provided.

In an attempt to further "create" evidence, the Examiner suggests that by looking to Khorasani with "the motivation of providing systems that either seek to change the physicians behavior or interfere with traditional practice routines which are often not adopted readily by physicians (See Khorasani, Col. 1, lines 36-40)," these significant missing elements from Claim 1 and not found in either Javors or Glass would be obvious to one skill in the art. It is important to remember that Javors as a whole teaches a new healthcare management model, and Glass, as a whole, teaches a physician compensation model that pays physicians based on number of patients seen (assembly line approach) and budgeted versus actual performance. Now, the Examiner suggests that these two patent documents (Javors and Glass) can somehow be combined with Khorasani et al. which as a whole teaches a computer system for decision support in the selection of diagnostic and therapeutic test and interventions for patients, namely for physicians ordering studies results of similar types of treatments used on patients in the past. Applicants respectfully submit that this awkward combination is just wrong and that no evidence has been provided to support a suggestion or motivation to do so.

More specifically, Khorasani et al. describes a computer system (a clinical information system) to order a study to be performed on a specified patient and indications for the study. "The received indications for the selected study are used to access a database of result codes for previous studies having the same indications, including studies performed on other patients. A result of the comparison of the selected study and specified indications to the result codes database is then sent to the ordering physician." (Col. 2, lines 14-22). The number of studies performed including those on other patients, for which results were significant for the same

indications out of the total number of studies performed for the same indications is provided as feedback to the ordering physician. This feedback relates the actual patient results to the appropriateness of the study, thus educating the ordering physician on the appropriateness of the study for the particular clinical indication, (Col. 2, lines 6-11), which can lead to a gradual change and ordering physician behavior (Col. 6, line 23). In other words, the feedback indicates to such ordering physicians which diagnostic and therapeutic tests and interventions are more likely to provide the ordering physician with the desired information. (Col. 1, lines 7-10). This has nothing to do with the problems addressed by the Applicants and nothing to do with the claimed invention.

Nevertheless, in view of these clear teachings in Khorasani et al., the Examiner has improperly taken portions of this patent document, namely Col. 1, lines 36-40, out of context which refer to physicians' generally hesitancy to adopt and use clinical information systems (see Col. 1, lines 33-40 in context) to allege that this is some type of evidence or support for combining the teachings related to using diagnostic systems with a patent document that teaches a new healthcare model and a patent document that teaches increasing the number of patients seen by and performance measures of a physician to increase there compensation. Applicants again respectfully submit that these lines in Khorasani are not evidence. That is, a discussion in a patent document (Khorasani et al.) related to physician hesitancy to adopt the use of computer system to help analyze patient symptoms over traditional practice routines is not evidence of motivation of one skilled in the art to combine the teachings of Khorasani (symptom diagnostic system) with Javors (new healthcare management model) and Glass (plan to increase number of patients seen by and performance measures of a physician to increase compensation). With all respect, this is like mixing apples and oranges in hopes of arriving at grapes. Not only can it not be done, but the suggestion to those in the agricultural art (in this instance, the healthcare services art) is absurd.

The Examiner has acknowledged that neither Javors, Glass, nor Khorasani explicitly disclose gathering data in a tangible computer medium from each of a plurality of physicians in a healthcare practice participating in an insurance network regarding management of ancillary medical costs. The Examiner has improperly introduced Dang (referencing Col. 10, line 50 to col. 11, line 18) as proposed evidence to support such premise, essentially stating that it would have been obvious to combine the features of Dang to the teachings of Javors, Glass, and

Khorasani, with the motivation of providing ancillary records which represent services which are incidental to direct evaluation, management, and treatment of a patient. The Examiner's statement alone, however, does not provide evidence of such motivation to combine such diverse references but highlights the improper piecemeal hindsight associated with the Examiner's analysis by turning to selected portions of yet a fourth patent document and highlights the strain and great extent the Examiner has gone to improperly reject the claims.

As stated previously, Dang describes a system which includes a computer-implemented method for profiling medical claims which groups health care services into episode treatment groups. (Col. 6, lines 21-28). One skilled in the art, in order to try to "create" the Applicants' claimed invention, would not seek to combine Dang with such diverse patent documents: Khorasani et al. (symptom diagnostic system), Javors (new healthcare management model), and Glass (plan to increase number of patients seen by and performance measures of a physician to increase compensation).

Not only is there nothing explicit in the cited patent documents that would suggest the modification of cross combining any of these the cited documents, there is also nothing implicit suggesting modifying the cited the documents, as the teachings, knowledge of one of ordinary skill in the art, and nature of the problem to be solved, as a whole, would not suggest doing so to those of ordinary skill in the art as is required in MPEP 2143.01 and *In re Kotzab*, 217 F.3d 1365, 1370, 55 USPQ2d 1313, 1317 (Fed. Cir. 2000). Further, not only is there no suggestion as to the desirability of the combination, discussed above, but also the combination would not in fact be desirable as the result would be absurd. When properly taken for what the patent documents teach as a whole, the result would be a new healthcare model that increases compensation to physicians for the number of patients seen, that diagnoses symptoms of the patients seen, and that groups the services provided into illness episodes to analyze delivery patterns for related symptoms. Clearly, this has nothing to do with the claimed invention and fails to provide an improved or enhanced method and system of collecting fees for managing a healthcare practice group.

Further, even if the references could somehow be combined or modified, which Applicants submit they cannot, this does not render the resultant combination obvious unless the cited art also suggests the desirability of the combination, which it does not. *See* MPEP 2143.01 ("the fact that the claimed invention is within the capabilities of one of ordinary skill in the art is

not sufficient by itself to establish *prima facie* obviousness"). Instead, the Examiner is required to provide evidence of such motivation and the desirability of making such a combination. And yet, nothing else has been shown by or set forth by the Examiner—other than the "out of context" citations to the patent documents. Therefore, for at least this reason, Applicants respectfully submit that a proper prima facie case of obviousness has not been set forth, that the present claimed invention is not obvious, and that Claims 1-20 define over the cited art.

No Reasonable Expectation of Success.

The Examiner has also failed to meet the second element of a prima facie case for obviousness because there must be, and there is not in this present case, a reasonable expectation of success. Clearly, from the discussion above and a quick examination of the patent documents, one skilled in the art would realize that the extensive modification of the patent documents cited by the Examiner and required by the Examiner's improper analysis fails to produce the Applicants' present claimed invention, namely an improved or enhanced method of collecting fees for managing a healthcare practice such as a plurality of physicians. Instead, the combination, as suggested above, results in an absurd new model of a healthcare system that increases physician compensation based on increasing the number of patients seen and yet uses a computer system that assists in diagnosing patients--again not the claimed invention. Therefore, the second element of a prima facie case of obviousness has not been satisfied, and for this reason as well, the claimed invention is not obvious and defines over the cited art.

The Cited Patent Documents Fail to Teach or Suggest All the Claim Limitations.

Finally, the Applicants respectfully submit that the Examiner has failed to meet the third element of a prima facie case for obviousness, which requires all claimed features be taught or suggested. In this case, as set forth above, the Examiner takes the position that Javors, Glass, Khorasani and Dang show all of the elements. Applicants submit that this simply is not true. First, with respect to Claim 1, the Examiner states that Javors discloses funding an incentive pool (Reserve Trust pool for a self-funded plan of a self-funded purchasing alliance, paragraph [0171]), but fails to disclose "paying funds from the funded incentive pool to the healthcare practice participating in the insurance network when the ancillary medical costs of the plurality of physicians in the healthcare practice do not decrease to a preselected level over a preselected period of time." (page 3 of Office Action). What the Examiner, however, does not say at this point with respect to Claim 1, for example, is that Javors also fails to disclose or suggest

"establishing a relationship between a healthcare consultation group and the healthcare practice participating in the insurance network to increase the plurality of physicians' profitability by reducing a risk of the healthcare practice not receiving a predetermined reimbursement amount for ancillary medical costs from the insurance network," "modifying behavior of at least one of the plurality of physicians in the healthcare practice for management of ancillary medical costs," "paying funds from the funded incentive pool to the healthcare practice participating in the insurance network if the ancillary medical costs of the plurality of physicians in the healthcare practice do not decrease to a preselected level over a preselected period of time," and "distributing predetermined percentages of savings attributed to the modifying behavior of the plurality of physicians ancillary medical cost management."

The Examiner basically has stated that with respect to Claim 1 (as well as Claim 8) that only the preamble and funding an incentive pool are disclosed in Javors and that only the preamble of Claim 13 is disclosed in Javors. Correspondingly, all of these other elements are taken as admitted as missing from Javors, and Applicants submit that this shows what a "stretch" (improper hindsight) is being made to allege this combination of patent documents, as described above.

Nevertheless, the Examiner then turns to Glass as another patent document in an awkward attempt to find these numerous missing pieces. Here, the Examiner alleges that Glass somehow shows "paying funds from the funded incentive pool to the healthcare practice participating in the insurance network if the ancillary medical costs of the plurality of physicians in the healthcare practice do not decrease to a preselected level over a preselected period of time"—yet this is not true. Glass, in fact, fails to teach or suggest such a step. The Examiner references pages 42-44, paragraphs 47-52 of Glass for this step, but this section of Glass describes a compensation plan to pay patients based on the number of patients seen (productivity) and performance (actual vs. budget)—again the assembly line concept. This fails to teach or suggest specifically "paying funds ....if (when) the ancillary medical costs of the plurality of physicians in the healthcare practice do not decrease to a preselected level over a preselected period of time." This step is simply not taught in Glass and is clearly a missing element in the Examiner's analysis. The Examiner asserts that the fact that Glass pays a general surgeons' base salary to be paid annually to read on "preselected time period" and then goes on to describe bonuses and incentives being paid to the general surgeon. This analysis, however,

misses the mark for several reasons: (1) again, the RVU compensation model described in Glass (see page 41, para. 41 of Glass) is paying physicians based on number of patients seen (productivity) and actual vs. budgetary performance (such as accurate medical records, patient satisfaction, etc.)—not even close to the model suggested in the instant application; (2) Glass fails to teach or suggest not paying if the ancillary medical costs do not decrease (Claims 1 and 8); and (3) Glass fails to teach or suggest distributing percentages of savings in an insurance network to the insurance network and the healthcare management consultation group if the ancillary medical costs decrease to a preselected level over a preselected time (Claim 13). Again, all of this is missing in Glass, and Applicants respectfully submit what the Examiner alleges is taught in Glass either is not what Applicants set forth in the claimed invention or simply is not taught in Glass.

The Examiner, then, inherently acknowledges that numerous elements in Claims 1, 8, and 13 are still missing from both Javors and Glass (see page 4, paras. 1-3 of the Office Action). Applicants submit, however, that even more than what the Examiner acknowledges is still missing from such a combination. Nevertheless, these numerous missing elements are supposedly found in a combination with Khorasani and Dang. This, however, also is simply not true. Again, Khorasani describes a computer system to assist doctors in diagnosing symptoms/diseases/illnesses, and Dang describes a computer-implemented method for profiling medical claims which groups health care services into episode treatment groups. To support the Examiner's assertions, the Examiner references Khorasani (Col. 5, lines 34 to Col. 6, line 26) which describes how a physician places an order on the computer system for a study in a decision support module. It guides the physician through what other studies show and what steps to take for treatment. This has nothing to do with collecting fees, and fails to teach or suggest increasing profitability of a practice group by not receiving reimbursement amounts for ancillary medical costs from the insurance network or distributing predetermined percentages of savings. In other words, this is simply not what is taught in the referenced Columns 5-6 of Khorasani. Thus, these remain clearly missing elements in the Examiner's analysis and yet are elements found in the claims. With respect to Dang, the analysis performed on each treatment episode is directed to uncovering casemix-adjusted differences in direct patient management based upon a compilation of medical claim data (Dang, col. 6, lines 41-49), with the ancillary services being of

minor consideration (Dang, col. 12, lines 6-11). Clearly, this further demonstrates missing elements in the Examiner's analysis that are elements found in the claims.

Accordingly, as a proper prima facie case of obviousness has not been shown for the independent claims, including lack of motivation, improper hindsight, and missing elements, Claims 1-20 have been shown to be nonobvious and define over the cited art.

Also, notably, Applicants submit that the Examiner also has failed to properly address and identify numerous elements in the dependent claims that are missing from Javors, Glass, Khorasani and Dang. For example, regarding Claims 2, 10, and 15, Applicants do not know what entities the Examiner identifies in Javors to constitute the "healthcare consultation group," "healthcare practice," or "insurance network," much less distribution of unused funds thereto. Regarding Claims 3, 11, and 16, Applicants were unable to find what portions of the cited passages the Examiner identifies as teaching collecting no fee by a healthcare consultation group if the healthcare practice does not reduce the ancillary medical costs to the preselected level over the predetermined period of time. Regarding Claims 4 and 12, Applicants were unable to find what portions of the cited passages the Examiner identifies as teaching a disproportionate distribution of predetermined savings, or as teaching a healthcare consultation group funding an incentive pool. Regarding Claims 5, 11, and 18, Applicants were unable to find what portions of the cited passages the Examiner identifies as teaching a billing fee structure provided from a healthcare consultation group much less one where savings are calculated by subtracting current ancillary medical costs from a predetermined baseline or cost value. Regarding Claims 6 and 19, Applicants were unable to find what portions of the cited passages the Examiner identifies as teaching a fee structure calculated by multiplying a predetermined percentage of ancillary cost savings by a number of patients participating in a healthcare practice. Regarding Claims 7, 12, and 20, Applicants were unable to find what portions of the cited passages the Examiner is referring to in support of the rejection regarding ancillary medical costs. Regarding Claim 9, Applicants were unable to find what portions of the cited passages the Examiner is referring to in support of the rejection. The cited passages refer to disease state management education programs. Regarding Claim 14, Applicants were unable to find what portions of the cited passages the Examiner identifies as teaching funding an incentive pool to be paid to the insurance network when modified medical management practices do not decrease ancillary medical costs. The restrictive measures described in the cited passages are referring to

limitations on providing services and not the described features of the claim. Regarding Claim 17, Applicants were unable to find what portions of the cited passages the Examiner is referring to in support of the rejection regarding funds distribution to a healthcare consultation group, an insurance network, and a healthcare practice.

If the Examiner maintains the rejections, the Applicants respectfully request the Examiner to specifically identify the structure or the described step which the Examiner equates to the above noted missing elements. Applicants respectfully submit that failure to do so by the Examiner makes this action improper and is a bit of a shell-game where Applicants have to improperly guess at the Examiner's meaning or analysis.

In commenting upon the references and in order to facilitate a better understanding of the differences that are expressed in the claims, certain details of distinction between the references and the present invention have been mentioned, even though such differences do not appear in all of the claims. It is not intended by mentioning any such unclaimed distinctions or making any amendments herein to create any implied limitations in the claims. Not all of the distinctions between the prior art and Applicants' present invention have been made by Applicants. For the foregoing reasons, Applicants reserve the right to submit additional evidence showing the distinctions between Applicants' invention to be novel and nonobvious in view of the prior art.

The foregoing remarks are intended to assist the Examiner in re-examining the application and in the course of explanation may employ shortened or more specific or variant descriptions of some of the claim language. Such descriptions are not intended to limit the scope of the claims; the actual claim language should be considered in each case. Furthermore, the remarks are not to be considered to be exhaustive of the facets of the invention that render it patentable, being only examples of certain advantageous features and differences which Applicants' attorney chooses to mention at this time.

CONCLUSION

In view of the above remarks Applicants submit that the claimed invention is in condition for allowance. As such, the issuance of a Notice of Allowance is respectfully requested.

Respectfully submitted,

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